

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15446

15446

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE ILLINOIS b. COUNTY COOK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHICAGO	
c. LENGTH OF STAY IN 1b 1 WEEK		d. STREET ADDRESS 5051 N. GLENWOOD AVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL COUNTY GEN. HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARA ELIZABETH ANDERSON		4. DATE OF DEATH Month Day Year 11 3 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 7, 1877
9. AGE (In years lost birthday) 89 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE	
11. BIRTHPLACE (County & State, or foreign country) COPENHAGEN DENMARK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILHELM LINDORFF		14. MOTHER'S MAIDEN NAME MARIAN LARSEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?	
17. INFORMANT ELMER O. ANDERSON		Address WESTMINSTER, MD. RT. #4	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC LYMPHOCYTIC LEUKEMIA 2040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC HEART DISEASE - (c) 2040 DUE TO			INTERVAL BETWEEN ONSET AND DEATH 1 MOS. YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHO PNEUMONIA - BILATERAL			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/27, 1966 to 11/3, 1966 , that (I) (we) last saw the deceased alive on 11/3, 1966 , and that death occurred at 1245 M, from causes and on the date stated above.			
22a. SIGNATURE Vincent J. Fiocco Jr.		22b. DATE SIGNED 11/13/66	
22c. PHYSICIAN'S NAME (Type) VINCENT J. FIOCCO, JR.		22d. ADDRESS WESTMINSTER, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF 11/14/66	23c. NAME OF CEMETERY OR CREMATORY GRACELAND CEMETERY	23d. LOCATION (City or town) (County) (State) CHICAGO ILLINOIS
24. FUNERAL DIRECTOR J. S. Myers, Jr. Westminster, Md.		25a. REC'D BY REGISTRAR DATE NOV 7 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1941

CHURCH OF DEATH

1941

CARROLL

WESTMINSTER

CARROLL COUNTY DEPT. OF HEALTH - 2021 N. GLENWOOD AVE.

CLARA

ELIZABETH PATTERSON

REMALE WHITE

JANUARY 1927

29

BOUL WHITE

GREENHILL DENMARK - 0-2-1

WILHELM LINDQVIST

MARRIAGE LICENSE

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ELMER ANDERSON



WESTMINSTER, IN

GRACE AND CEMETERY CHURCH

2-2-1941

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15447

CERTIFICATE OF DEATH

15447

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville		c. LENGTH OF STAY IN 1b 9y 3m 26d	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 6005 Cedonia Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thurman (Herman) - Arnold		4. DATE OF DEATH Month 11 Day 22 Year 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-1893
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Arnold (step-father)		14. MOTHER'S MAIDEN NAME Margaret Sheppard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 215-09-3708	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral suppurative nephritis DUE TO (c) -----			INTERVAL BETWEEN ONSET AND DEATH Days Weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (1) (this hospital) attended the deceased from 7-25 , 19 57 , to 11-22 , 19 66 , that (1) (we) lost the deceased alive on 11-22 , 19 66 , and that death occurred on 11-22 , 19 66 , from causes and on the date stated above.			
22a. SIGNATURE Heinz H. Klaatsch		22b. DATE SIGNED 11-22-66	
22c. PHYSICIAN'S NAME (Type) Heinz H. Klaatsch, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-26-66	23c. NAME OF CEMETERY OR CREMATORY Saint John's Cemetery	23d. LOCATION (City or Town) (County) (State) Ellicott City, Md.
24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road 21206		25a. REC'D BY REGISTRAR NOV 23 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TECHNICAL D. 15113



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

15448

CERTIFICATE OF DEATH

15448

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown			06.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Lydia Last Bair				4. DATE OF DEATH Month 11 Day 18 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1885	9. AGE (In years lost birthday) yrs. 81	IF UNDER 1 YEAR Months 11 Days 18	IF UNDER 24 HRS. Hours 18 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Carroll County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Hahn				14. MOTHER'S MAIDEN NAME Ammanda Eyer Sowers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Kenneth A. Bair, Taneytown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO 14201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 14 HRS YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/18 , 19 66 , to 11/18 , 19 66 , that (I) (we) last saw the deceased alive on 10/18 , 19 66 , and that death occurred at 10:32 P.M., from causes and on the date stated above.							
22a. SIGNATURE Vincent J. Fiocco				22b. DATE SIGNED 11/18/66		22c. PHYSICIAN'S NAME (Type) Vincent J. Fiocco	
22d. ADDRESS 8 Anchor Street, Westminster, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 21, 1966		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Taneytown, Carroll, Maryland	
24. FUNERAL DIRECTOR C.O. Fuss & Son, Taneytown, Md.				25. REC'D BY REGISTRAR NOV 21 1966		25b. REGISTRAR'S SIGNATURE Charles Inge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15449

CERTIFICATE OF DEATH

15449

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster			c. LENGTH OF STAY in 1b 20 Years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Westminster, Md. R. D. 2				d. STREET ADDRESS Westminster, Md. R. D. 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lester Middle Lammars Last Barnhart (Barnhart)				4. DATE OF DEATH Month Nov. Day 2 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/1/1901	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Shoe Worker				10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory		11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John H. Barnhart				14. MOTHER'S MAIDEN NAME Elizabeth Richman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-05-1217		17. INFORMANT Address Nettie M. Barnhart Westminster, Md. R-2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) unknown							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Emphysema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-17 , 19 64 , to 9-12 , 19 64 that (I) (we) last saw the deceased alive on 9-12 , 19 64 , and that death occurred at 8:30 A M, from causes and on the date stated above.							
22a. SIGNATURE Philip W. Mercer M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-2-66	
22c. PHYSICIAN'S NAME (Type) Philip W. Mercer				22d. ADDRESS 150 W. Main St. Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/5/66		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Run, Carroll Co., Md.	
24. FUNERAL DIRECTOR Richard A. Little				ADDRESS Littlestown, Pa.		25a. REC'D BY REGISTRAR DATE NOV 4 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

15450

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15450

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN lb ?		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL COUNTY GENERAL HOSPITAL		e. STREET ADDRESS Route 2		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILY Middle E. Last BRIGHTWELL		4. DATE OF DEATH Month November Day 27 Year 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1902	9. AGE (In years last birthday) yrs. 63	IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Worcester, Mass.	
13. FATHER'S NAME Frank F. Carlstrom		14. MOTHER'S MAIDEN NAME Augusta H. Islau		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-14-9536B		17. INFORMANT Mr. Wm. Clifford Brightwell	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Driver of car in auto-auto collision					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car in auto-auto collision		20f. (City or town) (County) (State) Carroll Md.	
20c. TIME OF INJURY Month, Day, Year 11:00 a.m. 11-27 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate		M.D. Charles S. Springate, M.D.		22. DATE SIGNED November 28, 1966	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/30/1966		23c. NAME OF CEMETERY OR CREMATORY Linganore Cemetery	
23d. LOCATION (City or Town) (County) (State) Frederick Co., Md.		25a. REC'D BY REGISTRAR DEC 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR C. M. Waltz		ADDRESS Box 241 Sykesville, Md.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15451

CERTIFICATE OF DEATH

15451

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville- Rural		c. LENGTH OF STAY IN 1b 2 mo. 1 day.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Antolina Gertrudis Rojas Cabarga		4. DATE OF DEATH 11-27-66	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-1877
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Cuba	
11. BIRTHPLACE (County & State, or foreign country) Cuba		12. CITIZEN OF WHAT COUNTRY? Alien	
13. FATHER'S NAME Amador Rojas		14. MOTHER'S MAIDEN NAME Isabel Gallardo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Springfield Hosp Medical Records, Md.	
17. INFORMANT Sykesville		Address Springfield Hosp Medical Records, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia DUE TO (b) Congestive Heart Failure DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH days years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ Month, Day, Year _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 9-26 , 19 66 , to 11-27 , 19 66 , that (we) last saw the deceased alive on 11-27 , 19 66 , and that death occurred at 11:35am on causes and on the date stated above.			
22a. SIGNATURE Renato R. Espina		22b. DATE SIGNED 11-27-66	
22c. PHYSICIAN'S NAME (Type) Renato Espina, M.D.		22d. ADDRESS Springfield State Hospital Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov 29, 1966	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D.C.
24. FUNERAL DIRECTOR F Esacki sons Hyattsville, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 30 1966	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15452					15452				
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Upperco</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Golden Age Dementia Home</u>					d. STREET ADDRESS <u>Emory Church Road</u>				
3. NAME OF DECEASED (Type or print) Last <u>CARR</u> Middle <u>BRADLEY</u> First <u>THOMAS</u>					4. DATE OF DEATH Month <u>Nov</u> Day <u>23</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/17/83</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Thomas Carr</u>					14. MOTHER'S MAIDEN NAME <u>Annie Iglehart</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>213-36-7941</u>		17. INFORMANT <u>Mrs. Eleanor Carr, Upperco, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subcutaneous Carcinoma</u> DUE TO (b) <u>Chronic Myocarditis</u> OUE TO (c) <u>Gravel Nephritis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 31, 1966</u> to <u>Nov 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 21, 1966</u> , and that death occurred at <u>3a M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>W. H. Martin</u>					22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <u>W. H. Martin</u>	
22d. ADDRESS <u>MARYLAND</u>					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>11/26/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Emory Methodist Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Tipton-Eline Funeral Home, Hampstead, Md.</u>					25a. REC'D BY REGISTRAR OATE <u>NOV 29 1966</u>				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15453

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15453

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 33yrs. 7mos. 1dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) CATTERTON, Essie		4. DATE OF DEATH Month NOVEMBER Day 29 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-1876
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 04 Days 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Catterton		14. MOTHER'S MAIDEN NAME Mary A. (last name unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-6633	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia by occlusion of larynx with peanut butter 921.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None (c) None PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epileptic psychosis.			
19. INTERVAL BETWEEN ONSET AND DEATH minutes			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) patient was eating supper & eating peanut butter with spoon. Patient was Nurse saw patient's tray slip to floor & she seemed to be choking.	
20c. TIME OF INJURY Month, Day, Year Hour am 6:10 p.m. 11-29 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital		20f. (City or town) (County) (State) Sykesville, Carroll Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher, M. D.		22. DATE SIGNED 11-29-66	
EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.		Address (Street, City, town, or county) 1385 W. Main St. Sykesville, Carroll Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 1, 1966	23c. NAME OF CEMETERY OR CREMATORY Friendship Ch. Cem	23d. LOCATION (City, town or county) (State) Friendship Md.
24. FUNERAL DIRECTOR Hutchins Funeral Home Owings, Md.		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Hutchins Funeral Home Owings, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE DEC 5 1966			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15454

CERTIFICATE OF DEATH

15454

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine			c. LENGTH OF STAY IN 1b 57 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Amelia First Condon Middle Last				4. DATE OF DEATH Nov. 18, 1966 Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1892		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William O. Porter				14. MOTHER'S MAIDEN NAME Mary E. Pickett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Mary Purdum Same As #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.V.D. 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis							INTERVAL BETWEEN ONSET AND DEATH Years,
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4/11/59		20f. (City or town) (County) (State) 11/18/66	
21. I certify that (I) (this hospital) attended the deceased from 4/11/59 , 19__ to 11/18/66 , 19__, that (I) was last saw the deceased alive on 11/16/66 , 19__, and that death occurred at 5:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE M.E. Robertson				22b. DATE SIGNED 11/18/66		22c. PHYSICIAN'S NAME (Type) Dr. M. E. Robertson	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/1966		23c. NAME OF CEMETERY Morgan Chapel		23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR ADDRESS C. M. Waltz Box 241 Sykesville, Md.				25a. REC'D BY REGISTRAR DATE NOV 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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15455

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15455

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u> c. LENGTH OF STAY IN 1b <u>8 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>POOLE ROAD</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u> d. STREET ADDRESS <u>POOLE ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FORREST RAY COOK</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 10 1917</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WORKER, STATE ROADS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STATE ROADS</u>	
11. BIRTHPLACE (State or foreign country) <u>ALBERENE, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LUTHER J. COOK</u>		14. MOTHER'S MAIDEN NAME <u>JULIA ANN SPROUSE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>223-14-0416</u>	
17. INFORMANT <u>MRS RUTH NULL COOK</u>		Address <u>SAME ADDRESS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis (acute) Sudden</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <u>W. Glenn Speicher</u> ADDRESS <u>135 E. Main St. Westminister, Carroll</u>			
22. DATE SIGNED <u>11-15-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/18/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ABERENE CEMETERY</u>		23d. LOCATION (City, town or county) <u>ABERENE, VA.</u>	
24. FUNERAL DIRECTOR <u>J. E. Murrill, Westminister, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 17 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles J. J.</u>			

15455

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15455

FOR STATE
HEALTH DEPT.

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FOR STATE
HEALTH DEPT.

15456

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15456

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville-rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RD #1		d. STREET ADDRESS RD #1	
3. NAME OF DECEASED (Type or print) First Middle Last Wakeman Cook		4. DATE OF DEATH Month Day Year 11 13 19 66	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1905
9. AGE (In years last birthday) 61		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm labor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Grant Cook		14. MOTHER'S MAIDEN NAME Emma Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-12-8884	
17. INFORMANT Mrs. Goldie Parks		Address Bartholow Rd. Rt. 3 Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolism following 9/21 DUE TO fractures of femur and pelvis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by tractor	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 8 18 1966		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm
20f. (City or town) Sykesville-rural Carr. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		22. DATE SIGNED 11/14/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/17/1966	23c. NAME OF CEMETERY OR CREMATORY White Rock Cemetery
23d. LOCATION (City or Town) Carroll Co., Md.		(County) (State)	
24. FUNERAL DIRECTOR C. M. Waltz		25a. REC'D BY REGISTRAR NOV 16 1966	
ADDRESS Box 241 Sykesville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12121

12121

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15457

CERTIFICATE OF DEATH

15457

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Golden Age Guest Home</u>		d. STREET ADDRESS <u>Glen Falls Road</u>	
3. NAME OF DECEASED (Type or print) <u>Edith G Cooper</u>		4. DATE OF DEATH <u>Nov 18 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from May Company</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Ensor</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Harmon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-8490</u>	
17. INFORMANT <u>Mr. Carroll M. Cooper</u>		Address <u>Reisterstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Genl. Anterior Pulmonary</u> DUE TO (c) <u>Chn. Cardiac</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8</u> <u>7</u> <u>2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1966</u> to <u>Nov 18, 1966</u> that (I) (we) last saw the deceased alive on <u>Nov 17, 1966</u> and that death occurred at <u>11:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>M N Martin</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>M N MARTIN</u>		22d. ADDRESS <u>Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Freeland Md.</u>
24. FUNERAL DIRECTOR <u>J. F. Eline & Sons</u>		ADDRESS <u>Reisterstown, Md.</u>	
25a. REC'D BY REGISTRAR <u>Nov 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15152

15152

UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15458 CERTIFICATE OF DEATH 15458											
1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SYKESVILLE c. LENGTH OF STAY IN 1b 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRINGFIELD STATE HOSP.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY 30-4 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY d. STREET ADDRESS 3826 HICKORY AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) David Henley CRAMER SR						4. DATE OF DEATH 11 16 1966					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-22-92		9. AGE (in years last birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Line man						10b. KIND OF BUSINESS OR INDUSTRY Telephone		11. BIRTHPLACE (County & State, or foreign country) BALT. CITY - MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME ALFUS CRAMER						14. MOTHER'S MAIDEN NAME SARAH Henley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WWI						16. SOCIAL SECURITY NO. 212-05-0932A		17. INFORMANT Hospital Records - Sykesville, Md. Address S.S. Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 11-3 , 19 66 to 11-16 , 19 66 that (I) (we) last saw the deceased alive on 11/16 19 66 , and that death occurred at 6:45 M, from the causes and on the date stated above. 22a. SIGNATURE Samuel P. Wise III M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 11-16-1966 22c. PHYSICIAN'S NAME (Type) SAMUEL P. Wise III 22d. ADDRESS S.S. Hospital Sykesville, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11-19-66 23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem 23d. LOCATION (City, town or county) (State) Towson Md 24. FUNERAL DIRECTOR Burgess Funeral Home ADDRESS 3631 Falls Rd B216 25a. REC'D BY REGISTRAR NOV 21 1966 25b. REGISTRAR'S SIGNATURE Charles Judge											

15152

15152

1. The first part of the report is a general description of the project. It includes a brief history of the project, its objectives, and the scope of the work. The second part of the report is a detailed description of the work done during the project. It includes a description of the methods used, the results of the work, and a discussion of the findings. The third part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project. It includes a brief history of the project, its objectives, and the scope of the work. The second part of the report is a detailed description of the work done during the project. It includes a description of the methods used, the results of the work, and a discussion of the findings. The third part of the report is a conclusion and a list of references.

3. The first part of the report is a general description of the project. It includes a brief history of the project, its objectives, and the scope of the work. The second part of the report is a detailed description of the work done during the project. It includes a description of the methods used, the results of the work, and a discussion of the findings. The third part of the report is a conclusion and a list of references.

4. The first part of the report is a general description of the project. It includes a brief history of the project, its objectives, and the scope of the work. The second part of the report is a detailed description of the work done during the project. It includes a description of the methods used, the results of the work, and a discussion of the findings. The third part of the report is a conclusion and a list of references.

5. The first part of the report is a general description of the project. It includes a brief history of the project, its objectives, and the scope of the work. The second part of the report is a detailed description of the work done during the project. It includes a description of the methods used, the results of the work, and a discussion of the findings. The third part of the report is a conclusion and a list of references.

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VR A15 (4)
20 M 1/66

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15459

CERTIFICATE OF DEATH

15459

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN Tb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO GENERAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> No. 1	
d. STREET ADDRESS <u>CHURCH ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ETHEL MARGUERITE CRAWMER</u> First Middle Last		4. DATE OF DEATH <u>NOV 5</u> 19 <u>66</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 19, 1898</u> 68 Yrs.
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS T BROTHERS</u>		14. MOTHER'S MAIDEN NAME <u>EMMA STONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-20-0263</u>	
17. INFORMANT <u>HARRY CRAWMER</u>		Address <u>NEW WINDSOR MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>42M</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>10 years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 5,</u> 19 <u>66</u> to <u>Nov 5,</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 5,</u> 19 <u>66</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>11/5/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>Church St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/8/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WINTERS</u>		23d. LOCATION (City or Town) (County) (State) <u>NEW WINDSOR RURAL MD</u>	
24. FUNERAL DIRECTOR <u>DR Hartzler & Sons</u>		25a. REC'D BY REGISTRAR <u>Nov 9</u> 19 <u>66</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15458

CERTIFICATE OF DEATH

32188

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "John" and "Mary" are faintly visible.]

[Faint text on the right margin, possibly a date or reference number.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15460

CERTIFICATE OF DEATH

15460

1. PLACE OF DEATH a. COUNTY Carroll ***** Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville, Md.		c. LENGTH OF STAY IN 1b 10 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		21701 (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) S. S. H. Springfield State Hosp.		d. STREET ADDRESS Route #6	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Earl Nicholas Davis		4. DATE OF DEATH Month Day Year 11 19 1966	
5. SEX m	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-1893
9. AGE (In years lost birthday) yrs. 73		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State, or foreign country) Frederick, Co, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Davis		14. MOTHER'S MAIDEN NAME Alice Sewell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-22-7938	
17. INFORMANT Alice Hill Rt 6 Frederick, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Congestive heart failure DUE TO (b) Pneumonia DUE TO (c) Dissecting Aneurysm of entire Aorta		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute brain syndrome associated with circulatory disorder		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that (I) (this hospital) attended the deceased from 11-9 , 19 66 , to 11-19 , 19 66 , that (we) last saw the deceased alive on 11-19 , 19 66 , and that death occurred on 11P.M. from causes on and on the date stated above.			
22a. SIGNATURE Sergio M. Palacio		22b. DATE SIGNED 11-19-99	
22c. PHYSICIAN'S NAME (Type) Sergio M. Palacio		22d. ADDRESS Sykesville, Maryland Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-23-66	
23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City or Town) (County) (State) Frederick Frederick, Md	
24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Maryland		25a. REC'D BY REGISTRAR DATE NOV 23 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15461		15461	
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> R2 06.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO HOSPITAL</u>		d. STREET ADDRESS <u>UNION MILLS</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE EZRA DINTERMAN</u>		4. DATE OF DEATH Month Day Year <u>NOV 1 19 66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 16-1883</u> 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	9. AGE (In years last birthday) yrs. <u>83</u>
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACOB DINTERMAN</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN BOSTIAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-14-8822</u>	
17. INFORMANT <u>LETTIE DINTERMAN</u>		Address <u>R2 MD WESTMINSTER</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia; Chronic lymphocytic leukemia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 28</u> , 19 <u>66</u> , to <u>Nov 1</u> , 19 <u>66</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>Nov 1</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>Nov 1, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Archer St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>NOV 4-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE</u>	23d. LOCATION (City or Town) (County) (State) <u>WOODSBORO MD</u>
24. FUNERAL DIRECTOR <u>D S Hartzler & Sons, New Windsor</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 3 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15151

CRITIQUE OF DATA

15151

1

1. The data are generally consistent with the theoretical predictions, but there are some discrepancies in the low energy region. The high energy region shows a clear peak at approximately 1.5 MeV, which is well explained by the model. The overall trend of the data is in good agreement with the theoretical curve, but the experimental error bars are quite large in some regions, particularly at low energies. The data points are well distributed across the energy range, and the theoretical curve provides a good fit to the experimental data. The results are consistent with the expected behavior of the system, and the model appears to be a reasonable representation of the physical process. The data are of high quality, and the theoretical predictions are well supported by the experimental results. The overall conclusion is that the data are in good agreement with the theoretical model, and the model provides a good description of the physical process. The results are consistent with the expected behavior of the system, and the model appears to be a reasonable representation of the physical process. The data are of high quality, and the theoretical predictions are well supported by the experimental results. The overall conclusion is that the data are in good agreement with the theoretical model, and the model provides a good description of the physical process.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15462

CERTIFICATE OF DEATH

15462

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN 1b <u>10yrs. 6mos. 12dys.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-New Windsor</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>R.D. 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BLANCHE</u> Middle <u>ETTA</u> Last <u>DODD</u>				4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>19 66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-25-92</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Boutcourt County Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Garst</u>			
14. MOTHER'S MAIDEN NAME <u>Ella Rader</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Records, Springfield State Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychoneurotic reaction, depressive reaction. Septicemia.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>5-5-36</u> , 19 <u> </u> , to <u>11-17-66</u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>11-17-66</u> 19 <u> </u> , and that death occurred at <u>5:00</u> M. from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Antonius Glahn, M.D.</u>				22b. DATE SIGNED <u>11-17-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Antonius Glahn, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11/19/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill Cemetery Frederick Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz Box 241 Sykesville, Md.</u>				25. REC'D BY REGISTRAR <u>NOV 21 1966</u>		26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12108

OFFICE OF CLERK

12108

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15463

CERTIFICATE OF DEATH

15463

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Goodtime</u>				c. LENGTH OF STAY IN 1b <u>03.2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Golden Age Trust Home</u>				d. STREET ADDRESS <u>1616 Hardwick Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Agnes R</u> Middle <u>Watson</u> Last <u></u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>26</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29, 1890</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Philip Reese</u>				14. MOTHER'S MAIDEN NAME <u>America Matthews</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO <u></u> (c) <u>Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July 24</u> , 19 <u>66</u> , to <u>Nov 26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 26</u> , 19 <u>66</u> , and that death occurred at <u>7 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>M N MAGISTON</u>				22b. DATE SIGNED <u>Nov 26-66</u>		22c. PHYSICIAN'S NAME (Type) <u>M N MAGISTON</u>	
22d. ADDRESS <u>Westminster Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-29-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto. Md</u>	
24. FUNERAL DIRECTOR <u>J H N. N. N. 269 Lake Rd, Riviera Bld</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 1</u> 19 <u>66</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12503

STATE OF NEW YORK

12503

IN SENATE,
January 12, 1903.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
JANUARY 1, 1903.
ALBANY:
J. B. LEECH, PRINTERS,
1903.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

15464

15464

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>50 Yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSPT.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSIE</u> Middle <u>-</u> Last <u>EBAUGH</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 10, 1893</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-9.</u>	
13. FATHER'S NAME <u>CHARLES H. WAGNER</u>		14. MOTHER'S MAIDEN NAME <u>MARY HAINES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>MR. JOHN B EBAUGH</u>		Address <u>SAME ADDRESS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Intestinal obstruction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. (City or town) (County) (State) <u>-</u>
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 20</u> , 19 <u>66</u> , to <u>Nov 26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 26</u> , 19 <u>66</u> , and that death occurred at <u>6:30</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u>		22b. DATE SIGNED <u>11/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Anchor St. Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/29/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEM. WESTMINSTER MD.</u>	23d. LOCATION (City or Town) (County) (State) <u>-</u>
24. FUNERAL DIRECTOR <u>J. E. Myers Jr. Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 29 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 29 1966</u>	

12484

CRIMINAL RECORD

12484

PERSONAL DATA		CRIMINAL RECORD	
NAME	DATE OF BIRTH	DATE OF ARREST	CHARGE
JOHN DOE	1925-01-15	1945-03-10	ROBBERY
JANE SMITH	1930-05-20	1948-07-15	THEFT
JOHN SMITH	1928-09-10	1946-11-20	ASSAULT
JANE DOE	1932-03-05	1949-02-10	DRUGS
JOHN SMITH	1925-01-15	1945-03-10	ROBBERY
JANE SMITH	1930-05-20	1948-07-15	THEFT
JOHN SMITH	1928-09-10	1946-11-20	ASSAULT
JANE DOE	1932-03-05	1949-02-10	DRUGS

RECORD OF ARRESTS

1. JOHN DOE, 1925-01-15, 1945-03-10, ROBBERY

2. JANE SMITH, 1930-05-20, 1948-07-15, THEFT

3. JOHN SMITH, 1928-09-10, 1946-11-20, ASSAULT

4. JANE DOE, 1932-03-05, 1949-02-10, DRUGS

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15465

CERTIFICATE OF DEATH

15465

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u> c. LENGTH OF STAY IN lb <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Imperial Nursing Home, 124 N. Main St</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Beltz City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> d. STREET ADDRESS <u>3000 Sycamore Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Annie</u>		First Middle Last <u>Flacconio</u>		DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1884</u>	9. AGE (In years last birthday) <u>82 yrs.</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cephalo, Italy</u>			
13. FATHER'S NAME <u>Joseph Imbruglio</u>		14. MOTHER'S MAIDEN NAME <u>Larab Barranco</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>715-50-630704</u>		17. INFORMANT Address <u>208 E Belvidere</u> <u>Joseph Flacconio (Son) Beltz, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO (b) <u>Anteriosclerotic Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (1) (this hospital) attended the deceased from <u>12/7</u> , 19 <u>65</u> to <u>11/9</u> , 19 <u>66</u> that (2) (we) last saw the deceased alive on <u>Nov 9</u> , 19 <u>66</u> , and that death occurred at <u>10:30</u> p.m. from the causes and on the date stated above.							
22a. SIGNATURE <u>W. H. Foard</u>				22b. DATE SIGNED <u>11/</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard</u>				22d. ADDRESS <u>M.D. Manchester, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>Nov 12 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE CEMETERY</u>			
23d. LOCATION (City, town or county) <u>WOODLAWN MD</u>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME</u>				25a. REC'D BY REGISTRAR <u>NOV 14 1966</u>			
ADDRESS <u>4210 BELAIR RD</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1940

RECEIVED

1940

23-1

TO THE HONORABLE CHIEF OF BUREAU OF THE ARMY
WASHINGTON, D. C.
FROM THE HONORABLE CHIEF OF BUREAU OF THE ARMY
WASHINGTON, D. C.
SUBJECT: [Illegible]
[The body of the letter contains several paragraphs of text that are mostly illegible due to fading and blurring. The text appears to be a formal communication between the Chief of the Bureau of the Army and another official.]

RECEIVED
[Illegible text in the right margin, possibly a routing slip or administrative notes.]

NOV 1 1940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
20 M 1/66

1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15466

CERTIFICATE OF DEATH

15466

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. LENGTH OF STAY IN 1b 06-1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cedarhurst Road		d. STREET ADDRESS Cecarhurst Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle E. Last Frebertshauser		4. DATE OF DEATH Month Nov. Day 6, Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1891	9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer at Rosewood State Hospital		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.	
13. FATHER'S NAME Conrad Frebertshauser		14. MOTHER'S MAIDEN NAME Mary Tawney		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-4927		17. INFORMANT Mr. Clifford E. Frebertshauser Finksburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO hypertension DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 days years years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 7-1-1960 to 11-6-66 , that (I) was lost saw the deceased alive on 11-5-1966 , and that death occurred at 5A M, from causes and on the date stated above.		22b. DATE SIGNED 11-6-66	
22a. SIGNATURE James G. Saffell		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) James G. Saffell	
22d. ADDRESS Reisterstown, Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/9/66	
23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Garden		23d. LOCATION (City or Town) (County) (State) Finksburg, Md.		24. FUNERAL DIRECTOR J. F. Eline & Sons	
25a. REC'D BY REGISTRAR NOV 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

15488

RECEIVED

15488

TO THE HONORABLE SECRETARY OF THE ARMY	
WASHINGTON, D. C.	
SIR:	
I have the honor to acknowledge the receipt of your letter of the 15th inst.	
and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.	
Very respectfully, Your obedient servant, [Signature]	
[Name]	
[Title]	
[Address]	
[City]	
[State]	
[Zip]	
[Phone]	
[Fax]	
[E-mail]	
[Web]	
[Social Media]	
[Other]	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15467

CERTIFICATE OF DEATH

15467

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> by COUNTY <u>Baltimore, City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville Md</u>		c. LENGTH OF STAY IN TB <u>26yr 8mo 1da</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Block</u> Last <u>Friedman</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/1909</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Babylon New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Block</u>		14. MOTHER'S MAIDEN NAME <u>Gussie Plava</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>XXXXXXXXXX</u>	
17. INFORMANT <u>Springfield State Hospital</u>		Address <u>Springfield State Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>Chronic glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>3. 1.</u> 19 <u>60</u> to <u>Nov. 2</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 2</u> 19 <u>66</u> and that death occurred at <u>7:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>I. E. HAPNER, M.D.</u>		22b. DATE SIGNED <u>11/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>I. E. HAPNER, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/3/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Agudas Achim Anshe Sfard</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12461

STATE OF NEW YORK

12461

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "STATE OF NEW YORK" and "12461" are visible.]

TO BE FORWARDED TO THE
CLERK OF THE COURT
IN THE CITY OF NEW YORK
WITHIN THE TIME
SPECIFIED IN THE
ORDER OF THE COURT

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15468

CERTIFICATE OF DEATH

15468

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) York Street				d. STREET ADDRESS York Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carel Middle Emanuel Last Frock				4. DATE OF DEATH Month November Day 23 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 17, 1903		9. AGE (In years last birthday) yrs. 63	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Bakery Route		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse W. Frock				14. MOTHER'S MAIDEN NAME Sarah Fink			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-1415		17. INFORMANT Mrs. Carel Frock Address York Street Taneytown, Md.			
18. CAUSE OF DEATH (Enter only one cause pertaining for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis + Myocardial Regeneration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Generalized DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Grand Mal Epilepsy, Multiple Sclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March , 19 66 to 11/23 , 19 66 that (I) (we) last saw the deceased alive on 11/15 , 19 66 and that death occurred at 2 P.M. from causes and on the date stated above.							
22a. SIGNATURE R. S. McVaugh M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/23/66	
22c. PHYSICIAN'S NAME (Type) R. S. McVaugh				22d. ADDRESS Taneytown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 26, 1966		23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City or Town) (County) (State) Taneytown, Carroll, Maryland	
24. FUNERAL DIRECTOR John H. Skiles ADDRESS C.O. Fuss & Son, Taneytown, Md.				25a. REC'D BY REGISTRAR NOV 25 1966 DATE		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12108

REPORT OF OFFICE

12108

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12

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2

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15469

CERTIFICATE OF DEATH

15469

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> RURAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 21214.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>4902 ARABIA AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>George</u> Last <u>Fuchs</u>				4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-95</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Police</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>CONRAD FUCHS</u>				14. MOTHER'S MAIDEN NAME <u>ANNA K. PRELLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-38-1592</u>		17. INFORMANT Address <u>Hospital Record: S.S. Hosp.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis generalized.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/10/66</u> , 19 <u>66</u> to <u>11/12/66</u> , that (I) (we) last saw the deceased alive on <u>10/12/66</u> , and that death occurred at <u>7:30</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Sergio Palacio</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-12-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SERGIO PALACIO</u>				22d. ADDRESS <u>SS Hosp. Sykesville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/16/66.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>f Charles Judge</u>	

15458

STATE OF TEXAS

15458

County of Tarrant

State of Texas

15458

City of Fort Worth

15458

County of Tarrant

State of Texas

15458

County of Tarrant

15458

County of Tarrant

State of Texas

City of Fort Worth

15458

County of Tarrant

State of Texas

15458

County of Tarrant

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15470

CERTIFICATE OF DEATH

15470

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 6yrs. 2mos. 28dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #6 d. STREET ADDRESS 4206 Powell Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (FILIPPO) PHILLIP First Middle Last (NMN) GASPARETTI		4. DATE OF DEATH Month Day Year NOVEMBER 16 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-1888
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Balto. City	
11. BIRTHPLACE (County & State, or foreign country) Italy (First papers in 1913)		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Anthony Gasparetti		14. MOTHER'S MAIDEN NAME Theresa Camarni	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-16-8569A	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Peripheral vascular disease DUE TO (c) Arterial occlusion, left leg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4533 6281		INTERVAL BETWEEN ONSET AND DEATH Days Years Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) CBS with cerebral arteriosclerosis, with psychotic reaction. Late latent syphilis. Uremia.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-18-60 , 19 60 , to 11-16-66 , 19 66 , that (I) (we) last saw the deceased alive on 11-16-66 , 19 66 , and that death occurred at 3:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 11-16-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/21/66.	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE NOV 18 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

15110

STATE OF TEXAS

15110

UNITED STATES

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

HOUSTON, TEXAS

SEPTEMBER 1, 1934

TO THE HONORABLE CHIEF JUSTICE

OF THE SUPREME COURT

OF THE STATE OF TEXAS

AT HOUSTON, TEXAS

FOR THE REASON THAT

YOUR HONORABLE COURT

IN ITS DECISION

IN THE CASE OF

THE STATE OF TEXAS

VS. THE STATE OF TEXAS

IN NO. 10,000

OF THE SUPREME COURT

OF THE STATE OF TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If a funeral home is used, the certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>15471</p> </div> </div>															
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u> c. LENGTH OF STAY in lb <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home 1280 Main St</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown Md.</u> d. STREET ADDRESS <u>Emory Rd</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Buelah Pearl Green</u>				4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1966</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 15 1888</u>		9. AGE (In years last birthday) <u>78 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (County & State, or foreign country) <u>New Emory Church Carroll Co.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Frank Rorer</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Mary Bond</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>no</u> (If yes give year or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u>217-48-1692 (son)</u>				17. INFORMANT <u>Stirling Green - uppers Md.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> (b) <u>Arterio-sclerotic C-V Disease</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4321</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>											
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u>May</u>		(County) <u>19</u>		(State) <u>66</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>May 19 1966</u> to <u>Nov 19 1966</u> that (I) (we) last saw the deceased alive on <u>Nov 19 1966</u> and that death occurred at <u>6:35 PM</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>M.C. Porterfield</u>				22b. DATE SIGNED <u>11-20-66</u>				22c. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>				22d. ADDRESS <u>Hampstead, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Emory Methodist Cemetery</u>				23d. LOCATION (City, town or county) <u>Carroll Co.</u> (State) <u>Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton-Eline</u>				ADDRESS <u>Hampstead, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Young</u>					

10101

10101

[Faint, mostly illegible text, possibly a list or report, with some handwritten notes and markings.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15472 CERTIFICATE OF DEATH 15472

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN 1b 15 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 52 GEORGE ST.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER d. STREET ADDRESS 52 GEORGE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER TURNER HAINES First Middle Last		4. DATE OF DEATH NOV. 12 1966 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 16, 1895 9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR, CLEANING & PRESSING EST.		11. BIRTHPLACE (County & State, or foreign country) CARROLL CO. MD.	
13. FATHER'S NAME JACOB A. HAINES		14. MOTHER'S MAIDEN NAME ELLA M. SINGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 219-14-8984	
17. INFORMANT MRS WALTER T. HAINES, SR.		Address SAME ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastases to liver & other organs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Operation at University Hosp for Ca 7-66 DUE TO (c) Carcinoma of lung		INTERVAL BETWEEN ONSET AND DEATH about 3 mo about 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) "cigarette smoking"			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 15, 1966 , to Nov. 12, 1966 , that (I) (we) last saw the deceased alive on Nov. 12, 1966 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE C. H. Billingslea M.D.		22b. DATE SIGNED 11-14-66	
22c. PHYSICIAN'S NAME (Type) C. H. Billingslea		22d. ADDRESS Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/15/66	
23c. NAME OF CEMETERY OR CREMATORY PLEASANT VALLEY CEM.		23d. LOCATION (City, town or county) (State) RURAL, WESTMINSTER, MD.	
24. FUNERAL DIRECTOR J. S. Myro, Jr.		25a. REC'D BY REGISTRAR Nov 17 1966	
ADDRESS WESTMINSTER, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

5561

SS023

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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15473

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15478

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINKSBURG				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINKSBURG			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT. 2, BOX 254-A				d. STREET ADDRESS RT. 2, BOX 254-A			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CORINNE Middle T. HANN Last XHANNX				4. DATE OF DEATH Month 11 Day 6 Year 1966			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-2-1917	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE REY				14. MOTHER'S MAIDEN NAME THERESA POLLOCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. ELMO L. HANN, RT. 2, Box 254-A, Finksburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas with liver involvement DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastric hemorrhage, Jondice, Anemia DUE TO (c) Bronchial pneumonia.				INTERVAL BETWEEN ONSET AND DEATH Oct. 29, 1966 11-6-66			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Oct. 29, 1966 to Nov. 6, 1966 that (I) (we) last saw the deceased alive on Nov. 6, 1966, and that death occurred at 1:30 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Howard E. Hall, M.D.				22b. DATE SIGNED Nov. 7, 1966			
22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D.				22d. ADDRESS Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-8-66		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOWARD H. HUBBARD, 4107 WILKENS AVENUE, 21229				ADDRESS 4107 WILKENS AVENUE, 21229		25a. REC'D BY REGISTRAR DATE NOV 10 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

15178

15275

STATE OF TEXAS
COUNTY OF DALLAS

15275

STATE OF TEXAS

COUNTY OF DALLAS

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at the City of Dallas, Texas, this 15th day of May, 1917.

15178

James E. Smith

NOTARY PUBLIC

BY MYSELF AND BY THE SIGNATURE OF THE SIGNER

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at the City of Dallas, Texas, this 15th day of May, 1917.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15474					15474						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY CARROLL					a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					b. COUNTY CARROLL						
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
RURAL WESTMINSTER 6 YEARS					WESTMINSTER						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS						
ROUTE #2 WESTMINSTER					ROUTE #2						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
WILLIAM - HANS BOROUGH					NOV. 15 1966						
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)			
MALE		WHITE		WIDOWED		MAR 29 1888		78 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
MACHINE OPER. CONSTRUCTION					CONSTRUCTION		PALASTINE TEXAS		UNITED STATE		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Unknown					Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT				
YES					WORLD WAR I, 205-10-224/4		MRS WILLIAM HANSBROUGH ROUTE #2 WESTMINSTER				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE											
DUE TO MYOCARDIAL INFARCTION											
DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from SEPT 1962 to NOV 15 1966 that (I) (we) last saw the deceased alive on NOV 15 1966 , and that death occurred at 10:55 AM , from the causes and on the date stated above.											
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
Daniel I Welliver					M.D.		11-15-66		DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
DANIEL I WELLIVER					19 RIDGE RD WESTMINSTER						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)					
Burial		11/18/66		Mt. Zion Cemetery		York, Pa. R. D. 7					
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE	
Richard A. Little					Littlestown, Pa.					DATE NOV 17 1966	
										Charles Judge	

MEDICAL CERTIFICATION

15114

15114

Unknown

Unknown

15114

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15475

CERTIFICATE OF DEATH

15475

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Hampstead			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hampstead	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Upper Beckleysville Road				d. STREET ADDRESS Upper Beckleysville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle HARMON Last HARMON				4. DATE OF DEATH Month 11 Day 29 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 11/3/03		9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 00 Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME G. Glenville Harmon				14. MOTHER'S MAIDEN NAME Florence Harmon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-01-3402		17. INFORMANT Address Mr. Wm. Harmon, Jr. Hampstead RD 2, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 434.1 IMMEDIATE CAUSE (a) Subm. edema DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemophysis						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 1 WK	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 11/27 , 19 66 , to 11/28 , 19 66 , that (1) (we) lost saw the deceased alive on 11/28 , 19 66 , and that death occurred at 5:40 M, from causes and on the date stated above.							
22a. SIGNATURE D. A. Wright				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/29/66	
22c. PHYSICIAN'S NAME (Type) D. A. Wright M.D.				22d. ADDRESS Greenmont, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/1/66		23c. NAME OF CEMETERY OR CREMATORY Grave Run Cemetery		23d. LOCATION (City or Town) (County) (State) Balto. Co Md.	
24. FUNERAL DIRECTOR Tipton-Eline				ADDRESS Hampstead, Md.		25a. REC'D BY REGISTRAR DATE DEC 2 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

25601

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VR A15ME
35D0 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <div style="border: 1px solid black; padding: 2px; text-align: center;">Carroll</div> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="border: 1px solid black; padding: 2px; text-align: center;">Rural-Hampstead</div> c. LENGTH OF STAY IN 1b <div style="border: 1px solid black; padding: 2px; text-align: center;">Shiloh Road</div> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <div style="border: 1px solid black; padding: 2px; text-align: center;">Maryland</div> b. COUNTY <div style="border: 1px solid black; padding: 2px; text-align: center;">Carroll</div> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="border: 1px solid black; padding: 2px; text-align: center;">Rural-Hampstead</div> d. STREET ADDRESS <div style="border: 1px solid black; padding: 2px; text-align: center;">Shiloh Road</div> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First FORREST Middle F. Last HARRIS </div>		4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month 11 Day 15 Year 1966 </div>	
5. SEX <div style="border: 1px solid black; padding: 2px; text-align: center;">Male</div>		6. COLOR OR RACE <div style="border: 1px solid black; padding: 2px; text-align: center;">White</div>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="border: 1px solid black; padding: 2px; text-align: center;">7/2/1909</div>	
9. AGE (In years last birthday) <div style="border: 1px solid black; padding: 2px; text-align: center;">57 yrs.</div>		10. UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
11. UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? <div style="border: 1px solid black; padding: 2px; text-align: center;">USA</div>	
13. FATHER'S NAME <div style="border: 1px solid black; padding: 2px; text-align: center;">James G. Harris</div>		14. MOTHER'S MAIDEN NAME <div style="border: 1px solid black; padding: 2px; text-align: center;">W. Alice Frank</div>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <div style="display: flex; justify-content: space-between;"> yes WW2 </div>		16. SOCIAL SECURITY NO. <div style="border: 1px solid black; padding: 2px; text-align: center;">220-07-8975</div>	
17. INFORMANT <div style="border: 1px solid black; padding: 2px; text-align: center;">Mrs. Mary R. Harris, Hampstead, Md.</div>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (acute) sudden DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <div style="border: 1px solid black; padding: 2px; text-align: center;">4201</div>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		22b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
23. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
24. ACTUAL SIGNATURE <div style="border: 1px solid black; padding: 2px; text-align: center;"> </div>		25. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 26. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 27. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, and County) 1315 W. 10th St. Hampstead, Md.	
28. EXAMINER'S NAME (Type) <div style="border: 1px solid black; padding: 2px; text-align: center;">W. E. E. Specker</div>		29. DATE SIGNED <div style="border: 1px solid black; padding: 2px; text-align: center;">11-15-66</div>	
30a. BURIAL, CREMATION, REMOVAL (Specify) <div style="border: 1px solid black; padding: 2px; text-align: center;">Burial</div>		30b. DATE THEREOF <div style="border: 1px solid black; padding: 2px; text-align: center;">11/18/66</div>	
30c. NAME OF CEMETERY OR CREMATORY <div style="border: 1px solid black; padding: 2px; text-align: center;">Hampstead Cemetery</div>		30d. LOCATION (City, town or county) (State) <div style="border: 1px solid black; padding: 2px; text-align: center;">Hampstead, Md.</div>	
31. FUNERAL DIRECTOR <div style="border: 1px solid black; padding: 2px; text-align: center;">Tipton-Eline Fun. Home, Hampstead, Md.</div>		32. REC'D BY REGISTRAR <div style="border: 1px solid black; padding: 2px; text-align: center;">NOV 21 1966</div>	
33. REGISTRAR'S SIGNATURE <div style="border: 1px solid black; padding: 2px; text-align: center;"> </div>		34. ADDRESS <div style="border: 1px solid black; padding: 2px; text-align: center;">1315 W. 10th St. Hampstead, Md.</div>	

15718

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONT. CO. CAP.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HVATTSVILLE		162	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL CO. GEN. HOSPITAL		d. STREET ADDRESS 5350 QUINCY ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last NELL BELL JOHNSTON		4. DATE OF DEATH Month Day Year NOV. 20 1966	
5. SEX F.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 3, 1880
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) MURRAY IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT EVANS		14. MOTHER'S MAIDEN NAME MARY ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 219-54-9041	
17. INFORMANT FRANCIS T. JOHNSTON		Address 12 HERBERT DRIVE, ELLICOTT CITY MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 20, 1966 , to Nov 20, 1966 , that (I) (we) last saw the deceased alive on Nov 20, 1966 , and that death occurred at 4:25 AM , from causes and on the date stated above.			
22a. SIGNATURE John S. Harshey		22b. DATE SIGNED 11/20/66	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS 8 Anchor St. Westminster, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 11/25/66	
23c. NAME OF CEMETERY OR CREMATORY RANDOLPH CEMETERY		23d. LOCATION (City or Town) (County) (State) RANDOLPH IOWA	
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE NOV 23 1966	

15471

EXHIBIT OF DEATH

15471

Collegiate School

Prisoner

John S. Harkney

John S. Harkney, M.D.

Examiner of Death

11/20/19

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15478

CERTIFICATE OF DEATH

15478

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Sykesville</u> c. LENGTH OF STAY IN 1b <u>9y. 7m. 18d.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5 E. 33rd Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Genevieve Tilden Kennard</u>				4. DATE OF DEATH Month Day Year <u>11 23 19 66</u>									
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/3/87</u>		9. AGE (In years last birthday) yrs. <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min. _____		IF UNDER 24 HRS. Hours Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edward Kennard</u>						14. MOTHER'S MAIDEN NAME <u>Sparks, Emma</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-30-5899</u>		17. INFORMANT Address <u>Springfield State Hospital records, Sykesville</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction with perforation of the left ventricle muscle</u> DUE TO (b) <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic reaction, chronic undifferentiated type.</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (this hospital) <u>attended</u> the deceased from <u>4/5/1957</u> to <u>11/23/1966</u> , that (we) last saw the deceased alive on <u>11/23/1966</u> , and that death occurred at <u>11 A.M.</u> from causes and on the date stated above.													
22a. SIGNATURE <u>Carlos G. Lavin</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11/23/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Carlos G. Lavin, M. D.</u>						22d. ADDRESS <u>Springfield State Hospital Sykesville, Maryland</u>							
23a. BURIAL, CREMATION, REMAINS (Specify)				23b. DATE THEREOF <u>11-26-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Chestertown, Maryland</u>			
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc.</u>						ADDRESS <u>1217 St. Paul St. Baltimore 2, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

12434

CERTIFICATE OF DEATH

12434

Name of deceased		Date of birth		Sex	
Age at death		Date of death		Place of death	
Cause of death		Occupation		Manner of death	
Signature of physician		Signature of registrar		Signature of informant	
Date of registration		Place of registration		County and State	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15479

CERTIFICATE OF DEATH

15479

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville c. LENGTH OF STAY IN 1b 32y 6m 26d d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Rfd. 1 d. STREET ADDRESS Downsville e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Franklin Last Kepler		4. DATE OF DEATH Month 11 Day 15 Year 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Harry Kepler		14. MOTHER'S MAIDEN NAME Clemmie M. Brandenburg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-54-0758	17. INFORMANT Hospital Records Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5411 Bilateral bronchopneumonia DUE TO (b) Perforated duodenal ulcer DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Days Day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with intracranial infection other than Syphilis, Epidemic encephalitis with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. --- 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) ---	20f. (City or town) (County) (State) ---
21. I certify that (a) (this hospital) attended the deceased from 4-19 , 19 38 , to 11-15 , 19 66 , that (b) (we) lost saw the deceased alive on 11-15 , 19 66 , and that death occurred at 9:45 M. from causes and on the date stated above.			
22a. SIGNATURE Heinz H. Klaatsch		22b. DATE SIGNED 11-15-66	22c. PHYSICIAN'S NAME (Type) Springfield State Hospital
23a. BURIAL, CREMATION, REMOVAL (Specify) B	23b. DATE THEREOF 11- 18- 66	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr.		25a. REC'D BY REGISTRAR NOV 18 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

15178

15178

UNITED STATES DEPARTMENT OF AGRICULTURE

Washington

Department

Division

Office

Room

Telephone

Address

City

State

Country

Post Office

Box

Number

Zone

Country

Remarks

Date

Signature

Signature

Official Name

Rank

File

Number

Volume

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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24. FUNERAL DIRECTOR	H. J. Silcox	ADDRESS	Maryland	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15481

CERTIFICATE OF DEATH

15481

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			c. LENGTH OF STAY IN 1b <u>56 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> <u>06.1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSPT</u>				d. STREET ADDRESS <u>162 WILLIS ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES GLOYD LEAHY</u> First Middle Last				4. DATE OF DEATH Month <u>NOV.</u> Day <u>7</u> Year <u>19 66</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 5, 1910</u>	
				9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRIAL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WESTMINSTER, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES G. LEAHY</u>				14. MOTHER'S MAIDEN NAME <u>MAMIE V. BARBER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>185-01-2890</u>		17. INFORMANT Address <u>SAME</u> <u>MRS KATHYLYN MELLOR LEAHY</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic pancreatitis</u> <u>5870</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 5</u> , 19 <u>66</u> , to <u>Nov 7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 7</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John S. Harshey</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>				22d. ADDRESS <u>Shirley St. Westminster, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/10/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER MD.</u>	
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., WESTMINSTER, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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NOV 1 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15482
15482

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville,				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pullen Nursing Home-8 First Ave.				d. STREET ADDRESS 3011 W. Belvedere Ave.			
3. NAME OF DECEASED (Type or print) William H. Lycett				4. DATE OF DEATH Nov. 2 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1879	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timekeeper		10b. KIND OF BUSINESS OR INDUSTRY Steel Foundry		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Michael Lycett				14. MOTHER'S MAIDEN NAME Ann Rebeca O'Neill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-9506		17. INFORMANT Mrs. Rose Lycett, 3011 W. Belvedere Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Uremic Coma 442X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Generalized Arteriosclerotic C.V.D. DUE TO (c) Nephrosclerosis; Anazarkia							INTERVAL BETWEEN ONSET AND DEATH 48 hours 12 yrs. 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basal Cell Carcinoma of skin							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 15, 1966 to Nov 2, 1966 , that (I) (we) last saw the deceased alive on Oct 31, 1966 , and that death occurred at 5:15 PM , from the causes and on the date stated above.							
22a. SIGNATURE Sani Okutman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov 2. 66	
22c. PHYSICIAN'S NAME (Type) Sani Okutman				22d. ADDRESS Sykesville, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/5/66		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lo Vernon Lemmon				ADDRESS 4611 Park Heights Av. Balto. Md		25a. REC'D BY REGISTRAR NOV 4 1966	
				25b. REGISTRAR'S SIGNATURE J Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 1d Film G382 11/14/66 mh

CERTIFICATE OF DEATH

Reg. Dist. No.

15483

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester, Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester, Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>206 York St.</i>		d. STREET ADDRESS <i>206 York St</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>William Edward Markel</i>		4. DATE OF DEATH Month Day Year <i>Nov 5 1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 25, 1878</i>
9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Elias Markel</i>		14. MOTHER'S MAIDEN NAME <i>Mary Rinehart</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>R20-01-6758</i>	
17. INFORMANT <i>Miss Anna Caltruder</i>		Address <i>Manchester, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO (b) <i>Arteriosclerotic Cardio Vascular Disease</i> DUE TO (c) <i>Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>5 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>11/11/66</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/5</i> , 1950, to <i>11/5</i> , 1966, that I last saw the deceased alive on <i>11/11</i> , 1966, and that death occurred at <i>8 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W H Foward</i>		ADDRESS (Street, city or town, state) <i>25 N Main St</i>	
PHYSICIAN'S NAME (Type) <i>W. H. Foward MD</i>		DATE SIGNED <i>11/5/66</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/8/66</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Manchester</i>		22d. LOCATION (City, town, or county) (State) <i>Manchester Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Tipton Elise</i>		ADDRESS <i>Hampstead, Md.</i>	
24a. REC'D BY REGISTRAR <i>NOV 9 1966</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: This certificate should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15488

CERTIFICATE OF DEATH

15488

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>	
5. PLACE OF BIRTH <i>New York City</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1925</i>	
9. NAME OF SPOUSE <i>Mary E. Smith</i>		10. PLACE OF MARRIAGE <i>New York City</i>	
11. DATE OF DEATH <i>Dec 10 1945</i>		12. TIME OF DEATH <i>10:30 AM</i>	
13. PLACE OF DEATH <i>Home</i>		14. CAUSE OF DEATH <i>Heart Disease</i>	
15. DISEASE OR INJURY <i>Coronary Artery Disease</i>		16. IMMEDIATE CAUSE OF DEATH <i>Myocardial Infarction</i>	
17. UNDERLYING CAUSE OF DEATH <i>Coronary Artery Disease</i>		18. MANNER OF DEATH <i>Natural</i>	
19. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		20. SIGNATURE OF WITNESS <i>Dr. A. B. Smith</i>	
21. SIGNATURE OF DECEASED <i>John J. Smith</i>		22. SIGNATURE OF SPOUSE <i>Mary E. Smith</i>	
23. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>		24. SIGNATURE OF CLERK <i>John J. Smith</i>	
25. SIGNATURE OF REGISTRAR <i>John J. Smith</i>		26. SIGNATURE OF DECEASED <i>John J. Smith</i>	

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF OBTAINING A GRAVE SPACE IN ANY CEMETERY IN THE STATE OF MARYLAND.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15484

CERTIFICATE OF DEATH

15484

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 mos. 3 dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS Route #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DANIEL OTHO MILLS				4. DATE OF DEATH Month Day Year November 11 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1884		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad (retired)		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James M. Mills				14. MOTHER'S MAIDEN NAME Mary Long			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 213-16-1601-A		17. INFORMANT Address Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Heart failure DUE TO (c) Arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH days	
						days	
						years	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-8-66 , to 11-11-66 , that (I) (we) last saw the deceased alive on 11-11-66 , and that death occurred at 8:45 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Dr. Antonius Glahn</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-11-66	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11.13.66		23c. NAME OF CEMETERY OR CREMATORIUM PARKHEAD E.U.B.		23d. LOCATION (City or Town) (County) (State) BIG POOL WASHINGTON MD,	
24. FUNERAL DIRECTOR <i>Howard Helton</i>				ADDRESS <i>Howard Helton</i>		25a. REC'D BY REGISTRAR DATE NOV 14 1966	
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

12184

STATE OF TEXAS

12184

County of _____ State of Texas

Know all men by these presents, _____ of the County of _____ State of Texas, for and in consideration of the sum of _____ Dollars, to _____ of the County of _____ State of Texas, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said _____ of the County of _____ State of Texas, all that certain _____

TO HAVE AND TO HOLD unto the said _____ heirs, heirs and assigns forever.

And the said _____ do hereby certify that the foregoing is a true and correct copy of the original of the same as the same appears from the records of the County Clerk of the County of _____ State of Texas.

Witness my hand and seal of office this _____ day of _____ A.D. 19____.

County Clerk

Notary Public

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15485

CERTIFICATE OF DEATH

15485

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
c. LENGTH OF STAY IN Ib 25yr.2mo.21dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Unknown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NORA Middle (NMN) Agnes Last OWENS		4. DATE OF DEATH Month November Day 11 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-14-00
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Washington Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eugene Davis		14. MOTHER'S MAIDEN NAME Rillie Dickson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-54-6591	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pyogenic meningitis, organism unknown DUE TO 3403 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 125 (b) Bilateral bronchopneumonia (c) Chronic brain syndrome associated with central nervous system syphilis, meningoencephalitic.		INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with central nervous system syphilis, meningoencephalitic.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-20-41 , 19__ to 11-11-66 , 19__, that (I) (we) last saw the deceased alive on 11-11-66 , 19__, and that death occurred at 1:40 A.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Antonius Glahn M.D.		22b. DATE SIGNED 11-11-66	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/13/66	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetary		23d. LOCATION (City or Town) (County) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR Rest Haven Funeral Capel ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR NOV 14 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15486

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G382 11/21/66 mh

CERTIFICATE OF DEATH

15486

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville, Md.			c. LENGTH OF STAY IN 1b 12y 7m 7d		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 1121 Gorsuch Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Harry Last Packham				4. DATE OF DEATH Month 11 Day 15 Year 19 66			
5. SEX m	6. COLOR OR RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-9-1878		9. AGE (In years last birthday) yrs. 88	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY McGinnack Co.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Packham				14. MOTHER'S MAIDEN NAME Elizabeth Sweeting			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes 1917-1919		16. SOCIAL SECURITY NO. 218-10-6838 A		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cecum 1530 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOPNEUMONIA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH years days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with disturbance of metabolism						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. -- 19 p.m. --		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from 4-8 , 19 54 , to 11-15 , 19 66 , that (b) (we) last saw the deceased alive on 11-15 , 19 66 , and that death occurred at 2:05 M, from causes and on the date stated above.							
22a. SIGNATURE Alfredo M. Labrit				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-15-66	
22c. PHYSICIAN'S NAME (Type) ALFREDO M LABRIT				22d. ADDRESS Springfield State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/17/66.		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214 ADDRESS				25a. REC'D BY REGISTRAR DATE NOV 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15487

CERTIFICATE OF DEATH

15487

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lelia Middle Virginia Last Pinkowski		4. DATE OF DEATH Month November Day 24 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-1889
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 15 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry T. Minter		14. MOTHER'S MAIDEN NAME Gertrude Copeland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-14-6977	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V.D. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS, With Cerebral Arteriosclerosis with Behavioral Reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/22/66 , 19__, to 11/24/66 , 19__, that (I) (we) last saw the deceased alive on 11/24/66 , 19__, and that death occurred at 8:45AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. Antonius Glahn		22b. DATE SIGNED 11/24/66	
22c. PHYSICIAN'S NAME (Type) Dr. Antonius Glahn		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/26/66	23c. NAME OF CEMETERY OR CREMATORY Parklawn	23d. LOCATION (City or Town) (County) (State) Rockville, Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike		25. REC'D BY REGISTRAR 28 1966	
26. DATE Rockville, Md.		27. REGISTRAR'S SIGNATURE [Signature]	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. (See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

15488

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15488

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 10 dag. 11 yrs./8 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3235 Elliott Street	
3. NAME OF DECEASED (Type or print) Theodore NMN RATAJCZAK		4. DATE OF DEATH Month November Day 19 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/21/12
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 11 Days 21 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Ratajczak		14. MOTHER'S MAIDEN NAME Pelagia Sobczak	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction. 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis. DUE TO (c) Exposure to cold weather and starvation. weeks PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental deficiency, undifferentiated (deaf mute)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher		22. DATE SIGNED 11/19/66	
EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street only, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 22-1966	
23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION (City, town or county) Baltimore, Maryland 21222	
24. FUNERAL DIRECTOR JOHN J. DUDA, Baltimore, Maryland 21222		25a. REC'D BY REGISTRAR NOV 23 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15489

15489

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 11yrs. 11mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield St. Hospital.				d. STREET ADDRESS R.F.D. #1 Braddock Ave. LaVale		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jessie Maudie Resley				4. DATE OF DEATH Month November Day 20 Year 1966			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-96		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,			10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Md. Cumberland,		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William A Kirtley				14. MOTHER'S MAIDEN NAME Annie J. Deatlehauser			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. None		17. INFORMANT Springfield St. Hospital Records,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Rectum with Metastasis DUE TO (c) to the liver and lungs.							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1-12-55 , 19__ to 11-20-66 , 19__, that (I) (we) last saw the deceased alive on 11-20-66 , 19__, and that death occurred at 12:50 AM , from causes and on the date stated above.							
22a. SIGNATURE Sergio W Palacio				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-20-66	
22c. PHYSICIAN'S NAME (Type) Sergio W Palacio				22d. ADDRESS Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/23/66		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland				25a. REC'D BY REGISTRAR NOV 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15490

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15490

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b Manchester	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County General Hospital		d. STREET ADDRESS R.D. 1	
3. NAME OF DECEASED (Type or print) First BRET Middle RHOTON Last RHOTON		4. DATE OF DEATH Month November Day 30 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/66
9. AGE (In years lost birthday) yrs. 3		IF UNDER 1 YEAR Months 3 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Rhoton		14. MOTHER'S MAIDEN NAME Joyce Bowers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James Rhoton, Manchester R.D.1 Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Enteritis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		22. DATE SIGNED 11/30/66	
EXAMINER'S NAME (Type) Charles S. Petty		M.D. 	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/2/66	23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park, Inc.
23d. LOCATION (City or Town) (County) (State) Carroll Co. Md.		23e. REC'D BY REGISTRAR DATE DEC 5 1966	
24. FUNERAL DIRECTOR Tipton-Eline		25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS Hampstead, Md.		25a. REC'D BY REGISTRAR DATE DEC 5 1966	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15491

15491

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 6mos. 8dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3200 Juneau Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARY ELLEN RICHARDSON			4. DATE OF DEATH NOVEMBER 24 19 66		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-2-1884		9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Greer Kent		14. MOTHER'S MAIDEN NAME Alice Whiteford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-50-2697		17. INFORMANT Records, Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram negative septicemia 9047 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary to acute suppurative hemorrhagic cystitis (c) Secondary to decubitus ulcers, infected PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction Fracture, left hip. 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury occurred on Warfield 20c. TIME OF INJURY Month, Day, Year 3:00 p.m. 9-25-1966 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Springfield Hospital 20f. (City or town) (County) (State) Sykesville Carroll Md 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE W. Glenn Speicher EXAMINER'S NAME (Type) W. Glenn Speicher, M. D. 22. DATE SIGNED 11/24/66 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Nov. 27, 1966 23c. NAME OF CEMETERY OR CREMATORY Slate Ridge 23d. LOCATION (City, town or county) (State) Delta, Penna. 25a. REC'D BY REGISTRAR John H. Harkins 25b. REGISTRAR'S SIGNATURE Charles Judge DATE NOV 29 1966					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15492

CERTIFICATE OF DEATH

15492

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 113 Carrollton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MAMIE Middle (NMN) Last SCHROEDER			4. DATE OF DEATH Month November Day 14 Year 19 66		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-86	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Germany	
13. FATHER'S NAME John Keller			14. MOTHER'S MAIDEN NAME Mrie Edel		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-6016		17. INFORMANT Records, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pancreatitis 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Arteriosclerotic heart disease					INTERVAL BETWEEN ONSET, AND DEATH Weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mental deficiency, undifferentiated					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-30-16, 19 to 11-14-66, 19 , that (I) (we) last saw the deceased alive on 11-14-66 19, and that death occurred at 2:00 p.m. M, from causes and on the date stated above.					
22a. SIGNATURE Agustin del Campo			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-14-66
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/17/1966	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Wm. J. Truhner & Sons			ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR NOV 17 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15493

CERTIFICATE OF DEATH

15493

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> <u>06.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GEN. HOSPITAL</u>		d. STREET ADDRESS <u>46 CARROLL ST.</u>	
3. NAME OF DECEASED (Type or print) <u>ROLAND</u> First <u>MC KINLEY</u> Middle <u>SHIPLEY</u> Last		4. DATE OF DEATH <u>NOV.</u> Month <u>29</u> Day <u>1966</u> Year	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>JULY 24, 1898</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN, ROAD CONTRACTORS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO. MD.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE A. SHIPLEY</u>		14. MOTHER'S MAIDEN NAME <u>EMILY J. WAGNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-03-6916A</u>	
17. INFORMANT <u>MRS. ROLAND M. SHIPLEY</u>		Address <u>SAME ADDRESS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 29</u> , 19 <u>66</u> , to <u>Nov 29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 29</u> , 19 <u>66</u> , and that death occurred at <u>4 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Harshey</u> M.D.		22b. DATE SIGNED <u>11/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>		22d. ADDRESS <u>8 Anchor St. Westminster, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/1/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER, MD</u>
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr., WESTMINSTER, MD.</u>		25a. REC'D BY REGISTRAR <u>DEC 1 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15494

CERTIFICATE OF DEATH

15494

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY in 1b <u>2 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		06/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO GENERAL HOSPITAL</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EDWARD EARL STULTZ</u> First Middle Last		4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 21, 1902</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOVEL OPERATOR CEMENT CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD STULTZ</u>		14. MOTHER'S MAIDEN NAME <u>EFFIE BARNHART</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-05-1721</u>	
17. INFORMANT <u>FLORENCE STULTZ</u>		Address <u>UNION BRIDGE MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMPHYSEMA - ADVANCED</u> 5020 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CHRONIC BRONCHITIS</u> (c) <u>COR PULMONALE</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>66</u> , to <u>11/3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Vincent J. Faocco Jr.</u> M.D.		22b. DATE SIGNED <u>11/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>VINCENT J FAOCCO JR</u>		22d. ADDRESS <u>WESTMINSTER MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/6/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>		23d. LOCATION (City or Town) (County) (State) <u>UNIONTOWN MD</u>	
24. FUNERAL DIRECTOR <u>W D Hartzler & Sons Union Bridge, Md</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

12436

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15495

CERTIFICATE OF DEATH

15495

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 8y. 1m. 30d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield Hospital, Sykesville, Md.				d. STREET ADDRESS 12 W. Preston Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Lucretia Last Whdgemuth				4. DATE OF DEATH Month 11 Day 11 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-1881		9. AGE (In years last birthday) yrs. 85	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marion Daneker				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-22-9455		17. INFORMANT Address Springfield Hospital, Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Bronchopneumonia DUE TO (c) 4200						INTERVAL BETWEEN ONSET AND DEATH Years Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 9-13- , 1958 , to 11-11-66 , that (X) (we) last saw the deceased alive on 11-11-1966 , and that death occurred at 4:40 a.m. from causes and on the date stated above.							
22a. SIGNATURE <i>Ilse Kamm</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-11-66	
22c. PHYSICIAN'S NAME (Type) Dr. Ilse Kamm				22d. ADDRESS Springfield State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-14-66		23c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		23d. LOCATION (City or Town) (County) (State) Cambridge, Md.	
24. FUNERAL DIRECTOR <i>Harry W. Knight</i>				25a. REC'D BY REGISTRAR <i>Sykesville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
15496					15496					
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Mt. Airy</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Mt. Airy</u> 16.1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.D. 2</u>					d. STREET ADDRESS <u>R.D. 2</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>William Arthur Woodward</u>			First Middle Last		4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 30, 1904</u>		9. AGE (In years last birthday) <u>61</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Arthur P. Woodward</u>					14. MOTHER'S MAIDEN NAME <u>Rachel Zepp</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>219-14-8774</u>		17. INFORMANT <u>Mrs. Viola M. Woodward</u>			Address <u>Same As #2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 4201 DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>3 1/2 years</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>August 19</u> 19 <u>66</u> , and that death occurred at <u>7:50</u> p.m. from the causes and on the date stated above.										
22a. SIGNATURE <u>W.B. Culwell</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/7/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>					22d. ADDRESS <u>900 So Main St Mt. Airy, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/9/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Springs</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co., Md.</u>				
24. FUNERAL DIRECTOR <u>C. M. Waltz</u>					ADDRESS <u>Box 241 Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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